HANKINS & SOHN

Plastic Surgery Associates

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Name:_____Date_____

SOCIAL

Occupation_____

Age_____ Sex: Male □ Female □ Married: Yes □ No □

Responsible Adult to assist during recovery Yes □ No □

HABITS

Smoke Yes □ No □ Amount_____
Coffee/Tea/Cola Yes □ No □ Amount_____
Alcohol Yes □ No □ Amount_____
Daily Exercise Yes □ No □ Amount_____

MEDICATIONS: List dose or number of pills per day

Prescription Drugs

_____
_____
_____
_____

Non-Prescription Drugs (Vitamins:Herbs)

_____
_____
_____
_____

Regular Aspirin Use Yes □ No □ Dosage & frequency_____
NSA(Advil, Motrin, Ibuprofen) Yes □ No □ Dosage & frequency_____
Cortisone Injections Past Year Yes □ No □ Dosage & frequency_____

Drug Allergy (List drug and type of reaction)_____

Latex Allergy: Yes □ No □ Tape Allergy: Yes □ No □

FAMILY HISTORY:

Have any blood relatives had the following problems:

Abnormal bleeding:	Yes □	No □	Hypertension	Yes □	No □
Abnormal clotting:	Yes □	No □	Kidney Disease	Yes □	No □
Anesthesia Problems:	Yes □	No □	Tuberculosis:	Yes □	No □
Cancer:	Yes □	No □	Other Illness:	Yes □	No □
Coronary Surgery:	Yes □	No □			
Diabetes:	Yes □	No □			
Heart Attack	Yes □	No □			

Please describe questions with a "Yes" answer_____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal bleeding	Yes □	No □	Heart Attack	Yes □	No □
Abnormal clotting	Yes □	No □	Hepatitis	Yes □	No □
Acid regurgitation	Yes □	No □	Hypertension	Yes □	No □
Anemia	Yes □	No □	Sleep Apnea	Yes □	No □
Angina	Yes □	No □	Snoring	Yes □	No □
Asthma	Yes □	No □	Weight gain	Yes □	No □
Diabetes	Yes □	No □	Weight loss	Yes □	No □
Fainting Spell	Yes □	No □	Other	Yes □	No □

Please describe questions with a "Yes" answer_____

Have you ever had a blood transfusion? Yes □ No □ If yes when_____
Have you been treated for HIV? Yes □ No □ If yes when_____
Do you wear contacts? Yes □ No □ Eye glasses Yes □ No □ Dentures? Yes □ No □
Previous surgery, year and type of procedure_____

Any Complications from anesthesia?_____

WOMEN PATIENTS ONLY:

Number of pregnancies___ Number of children___ Last menstrual period_____Did you breast feed? Yes □ No